

STATE OF MAINE
BOARD OF DENTAL PRACTICE
APPLICATION FOR REGISTRATION
FOR SUPERVISED, CLINICAL EXPERIENCE

- Moderate Sedation – Level I (Enteral)
- Moderate Sedation – Level II (Parenteral)
- Deep Sedation and/or General Anesthesia



Maine Board of Dental Practice
143 State House Station
Augusta, ME 04333-0143

Office Telephone: (207) 287-3333
Office Facsimile: (207) 287-8140
TTY users call Maine Relay 711
Website: www.maine.gov/dental

APPLICANT INFORMATION GUIDE

The application material you have requested from the Board of Dental Practice is enclosed. It contains all the relevant materials you need to complete your application for registration in the State of Maine. Please read all the information carefully. If you have any questions after reading this packet, please call or e-mail our office.

FURNISHED TO APPLICANT

- Application Information Guide
- Registration Application
- Maine's Prescription Monitoring Program website
- Maine's Mandated Reporter Requirements for Suspected Child Abuse website
- Maine's Medical Professionals Health Program website

ADDITIONAL RESOURCES

- Board of Dental Practice Statute, Title 32, Chapter 143

Please read these carefully and review periodically for changes. You are responsible for knowing and complying with all Maine Laws throughout your licensure.

Available: <http://legislature.maine.gov/legis/statutes/32/title32ch143sec0.html> or call (207) 287-3333.

- Board of Dental Practice Rules

Please read these carefully and review periodically for changes. You are responsible for knowing and complying with all Board Rules throughout your licensure.

Available: <http://www.maine.gov/sos/cec/rules/02/chaps02.htm#313> or call (207) 287-3333.

- Statutory Authority, Titles 5 & 10

Available: <http://www.mainelegislature.org/legis/statutes/10/title10ch901sec0.html>

<http://www.mainelegislature.org/legis/statutes/5/title5ch341sec0.html>

APPLICATION INFORMATION GUIDE

- **Mandated Reporter Requirements for Suspected Child Abuse:** Maine law requires that dentists and dental hygienists immediately report or cause a report to be made to the Maine Department of Health and Human Services (DHHS) when the licensee knows or has reasonable cause to suspect that a child has been or is likely to be abused or neglected or that a suspicious child death has occurred. Mandated Reporter Training and additional information regarding mandated reporting can be found at:
<https://www.maine.gov/dhhs/ocfs/provider-resources/reporting-suspected-child-abuse-and-neglect/mandated-reporter-information>
- **Maine's Prescription Monitoring Program (PMP):** The PMP is a tool created to prevent and detect prescription drug misuse and diversion, and improve patient care through better coordination of care. PMP maintains a database of all transactions for schedule II, III and IV controlled substances dispensed in the State of Maine. This database is available free online to prescribers and dispensers by the Office of Substance Abuse and Mental Health Services (SAMHS) in the Maine Department of Health and Human Services. The database is searchable online, so it is available anywhere one has Internet access. Clinicians can use the program to check the history of a new patient and to monitor on-going treatment. PMP is another tool clinicians can add to their toolkit for preventing and intervening against misuse and diversion of prescription drugs. FMI about the program visit:
<http://www.maine.gov/dhhs/samhs/osa/data/pmp/index.htm>
- **Maine's Medical Professionals Health Program (MPHP):** The MPHP works cooperatively with six Maine boards of licensure, hospitals, medical staffs, and professional associations to ensure that professionals in need of treatment and services get the help they need. The MPHP is not a treatment program, but its staff will help professionals to find the resources they need, to better understand the treatment and recovery process, and to implement strategies for return to safe practice. <https://www.mainemphp.org/>
- **10 Day Reporting Requirement:** Please be advised, pursuant to 32 MRS §18352, licensees and applicants are to report to the Office, in writing, any change of name or address on file with the Office, any criminal conviction, any revocation, suspension or other disciplinary action taken in this or any other jurisdiction against any occupational or professional license held, or any material change set forth in this application within ten (10) days:

Registration – Supervised Clinical Experience

Pursuant to 32 M.R.S. §18348 (2), a dentist who holds a permit to administer sedation and/or general anesthesia pursuant to section 18379 may register another dentist under that dentist's license for the purpose of providing clinical supervision in administering sedation or general anesthesia under direct supervision.

A registration under this subsection expires one year from the date the registration is granted. Applicants must complete an application, pay the required fees, and submit a letter from the supervising dentist describing the practice settings in which supervision will occur, as well as attesting that these arrangements are commensurate with the registrant's education, training and competency.

APPLICATION INFORMATION: Applicants for registration must submit the documentation and fee(s) as outlined in the checklist below.

- Completed and signed Application (pgs. 1 - 6)
- Payment of fees: application fee \$50.00; registration fee \$200.00
- Clinical Supervision Form
- Verification of Clinical Supervision Form (to be completed after the supervised experience)
- Current; valid CPR or BLS certification

Note: All fees can be in one payment.

PLEASE NOTE:

- **Submit your application materials to the Board by US mail or hand delivery to our office. Faxed submissions will not be accepted.** Your application will be reviewed and processed in the order that it was received. Application reviews generally take at least two weeks, barring any action required by the full Board, or any high volume renewal of licensure periods.
- Pursuant to M.R.S. Chapter 143 §18341 (3), An applicant has 90 days after being notified of the materials needed to complete the application to submit those materials to the board. You will be notified by mail if there are deficiencies with your application. You may also check the Board's website at www.maine.gov/dental. It is the responsibility of the applicant to see that all documentation is completed and returned to the Board for consideration. Failure to complete the application within that 90-day period may result in a denial of the application.

STATE OF MAINE / BOARD OF DENTAL PRACTICE

Mailing Address: 143 State House Station, Augusta, Maine 04333-0143

Phone: (207) 287-3333 Fax: (207) 287-8140 TTY users call Maine Relay 711 Website: www.maine.gov/dental

Frequently Asked Questions:

- **Where do I send my application?** Our mailing address is 143 State House Station, Augusta, Maine 04333- 0143.
- **Where are you located?** 161 Capitol Street, Augusta, Maine.
- **What hours are you open?** 8:00 a.m. to 5:00 p.m. weekdays.
- **Can I come to Augusta to drop off my application?** Yes; however, it will not be reviewed and approved the same day.
- **Can I come to Augusta to pick up my license?** You will not receive a paper license. You will receive written notification from the Board approving or denying your registration application.
- **How can I check the status of my application?** You can check our website: www.maine.gov/dental
- **Can I fax my application?** No.

NOTICES

BACKGROUND CHECK: Pursuant to 5 M.R.S.A. §5301 - 5303, the State of Maine is granted the authority to take into consideration an applicant's criminal history record. The Maine Board of Dental Practice requires a criminal history records check as part of the application process for all applicants.

PUBLIC RECORD: This application is a public record for purposes of the Maine Freedom of Access Law (1 MRSA §401 et seq). Public records must be made available to any person upon request. This application for licensure is a public record and information supplied as part of the application (other than social security number and credit card information) is public information. Other licensing records to which this information may later be transferred will also be considered public records. Names, license numbers and mailing addresses listed on or submitted as part of this application will be available to the public and may be posted on our website.

SOCIAL SECURITY NUMBER: The following statement is made pursuant to the Privacy Act of 1974 (§7(B)). Disclosure of your Social Security Number is mandatory. Solicitation of your Social Security Number is solely for tax administration purposes, pursuant to 35 MRSA §175 as authorized by the Tax Reform Act of 1975 (42 USC §405(C)(2)(C)(1)). Your Social Security Number will be disclosed to the State Tax Assessor or an authorized agent for use in determining filing obligations and tax liability pursuant to Title 36 of the Maine Revised Statutes. No further use will be made of your Social Security Number and it shall be treated as confidential tax information pursuant to 36 MRSA §191.

Before you seal the envelope, did you:

- Complete every item on the application including the criminal background disclosure question?
- Sign and date your application?
- Include the required fee(s). Make checks payable to "Maine State Treasurer" or complete the credit card section on the application? **DO NOT SEND CASH.**
- Make a copy of your application to keep for your records?



**STATE OF MAINE
BOARD OF DENTAL PRACTICE**
143 State House Station, Augusta, ME 04333-0143

REGISTRATION APPLICATION

(Revised 12/2022)

APPLICANT INFORMATION (please print)			
FULL LEGAL NAME	<i>FIRST</i>	<i>MIDDLE INITIAL</i>	<i>LAST</i>
ANY OTHER NAMES EVER USED			
DATE OF BIRTH	<i>mm / dd / yyyy</i>	SOCIAL SECURITY NUMBER	
MAILING ADDRESS			
CITY	STATE	ZIP CODE	COUNTY
PHONE ()	FAX ()	E-MAIL	

BACKGROUND CHECK and 10 DAY REPORTING NOTICE

Pursuant to 5 MRS §5301 - 5303, the State of Maine, Board of Dental Practice is granted the authority to take into consideration an applicant's criminal history record. In addition, the Board of Dental Practice requires licensees to report to the Board criminal convictions within 10 days.

Board of Dental Practice

Required Fee: \$250.00

Office Use Only

1446 - \$ 50.00
1421 - \$200.00

Please Select Registration Type:

- Moderate Sedation Level I (Enteral) Training
- Moderate Sedation Level II (Parenteral) Training
- Deep Sedation / General Anesthesia Training

Office Use Only

Check # _____
Amount: _____
Cash # _____
License # _____

PAYMENT OPTIONS:

Make checks payable to "Maine State Treasurer" – if you wish to pay by credit or debit card, fill out the following:

NAME OF CARDHOLDER (please print)	<i>FIRST</i>	<i>MIDDLE INITIAL</i>	<i>LAST</i>
ADDRESS OF CARDHOLDER (please print)			
I authorize the Maine Board of Dental Practice to charge my card the following amount: \$ _____			
<input type="checkbox"/> VISA <input type="checkbox"/> M/C <input type="checkbox"/> Discover <input type="checkbox"/> AMEX			
<input type="checkbox"/> I understand that fees are non-refundable			
Card number:	Expiration Date:		<i>mm / yyyy</i>
SIGNATURE		DATE	

Credentialing History

Have you ever held a professional license/certification/registration in this or any other state/country?

YES NO

If yes:

Profession	License #	State/Country	Date Issued	Expiration Date

Specialty / Drug Enforcement Administration

Do you hold a specialty certification? If so, please list and submit a copy of your specialty certification: _____.

Do you hold a DEA registration? If so, please list #: _____.

Residency and/or Sedation Program Information

Name of School or Program:

Mailing Address:

City:

State:

Zip Code:

Dates:



STATE OF MAINE
Board of Dental Practice

143 STATE HOUSE STATION
 AUGUSTA, ME 04333-0143

CLINICAL SUPERVISION FORM

Dentist Applicant Information

Name of Dentist Applicant: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Dentist Supervisor Information

Name of Supervisor: _____ License and Permit Number: _____

Practice Name and Location: _____

City: _____ State: _____ Zip Code: _____

Dentist Supervisor - Registration Agreement

- 1) Location(s) of the clinical supervision: _____
- 2) Duration(s) of the clinical supervision: _____
- 3) Anticipated procedures to be completed under my supervision in coordination with Board Rule, Chapter 14 governing the use of sedation and/or general anesthesia. The following procedures will be performed under the level of supervision as listed below:

Note: Pediatric clinical experience requirements - children must be aged 12 and under, and a minimum of 4 pediatric cases must be successfully managed.

A.	Direct Supervision
B.	Direct Supervision
C.	Direct Supervision

By signing, I understand that the Maine Board of Dental Practice will rely upon this information to authorize the dentist applicant to perform procedures under my supervision in accordance with the regulations outlined in Board Rule, Chapter 14. I also agree to not commence supervision of this applicant until the application is approved by the Board.

SUPERVISOR'S SIGNATURE: _____ DATE: _____

Licensure / Disciplinary Questions

The following questions must be answered. If you circle "YES" to any question numbered 1 through 19, then please provide additional information such as a written explanation regarding the disclosure, along with additional documentation relevant to the disclosure.

1. Have you ever submitted an application for a professional or occupational license, certification, registration, or permit to any authority, other than the Maine Board of Dental Practice, that was not approved or that was approved subject to a condition, limitation, or restriction?

YES NO

2. Has any professional or occupational licensing, registration, or certifying authority, other than the Maine Board of Dental Practice, ever disciplined or otherwise imposed any sanctions, fines, probation, limitations, or restrictions on any license, certification, registration, or permit held by you?

YES NO

3. Have you ever entered into any type of settlement agreement with any professional or occupational licensing, registration, or certifying authority other than the Maine Board of Dental Practice?

YES NO

4. Are you aware of any complaints filed with any professional or occupational licensing, registration, or certifying authority, other than the Maine Board of Dental Practice, against any license, certification, registration, or permit held by you, for which you have not received a notice of final dismissal?

YES NO

5. Are you aware of any investigations or inquiries undertaken by any professional or occupational licensing, registration, or certifying authority, other than the Maine Board of Dental Practice, that involve, to any extent, any license, certification, registration, or permit held by you, for which you have not received a notice of final closure or dismissal?

YES NO

6. Have your practice privileges ever been restricted?

YES NO

7. Have you ever left a dental licensing jurisdiction, other than the Maine Board of Dental Practice, while a complaint or allegation was pending?

YES NO

8. Have you ever been denied registration or had your ability to administer, prescribe, or dispense controlled substances modified, restricted, suspended, revoked, or voluntarily suspended?

YES NO

Licensure / Disciplinary Questions (Continued)

9. Have you ever received a sanction from the Center for Medicare and Medicaid Services or any state Medicaid program?

YES NO

10. Have you ever rendered any dental services illegally?

YES NO

11. Are you currently dependent on the use of alcohol or habituating drugs?

YES NO

12. Are you currently engaged in the illegal use of drugs or misuse of any drugs?

YES NO

13. Are you currently participating in a substance abuse and/or alcohol or drug treatment program, or have you been diagnosed with a substance abuse disorder that in any way currently affects or limits your ability to practice safely and in a competent and professional manner?

YES NO

14. Do you currently use any chemical substance(s), including alcohol or drugs, which in any way impairs or affects your ability to practice your dental profession with reasonable skill and safety?

YES NO

15. Do you have or have you ever been diagnosed with or treated for a medical, mental, physical, emotional, nervous, or behavioral disorder or condition that in any way currently limits or impairs your ability to practice safely or to function as a dental professional?

YES NO

16. Have you ever asserted any condition or impairment as a defense or in mitigation of, or as an explanation for your actions in the course of any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination action (educational, employer, government agency, professional organization, or licensing authority)?

YES NO

17. Have you been named in any lawsuit involving your practice as a dental professional that was adjudicated to any degree in favor of the other party?

YES NO

Licensure / Disciplinary Questions (Continued)

18. Have you been named in any lawsuit involving your practice as a dental professional that was settled by the parties?

YES NO

19. Are you currently in default on payment of student loans?

YES NO

Maine Statutes and Rules

20. Have you read the statutes and rules governing dental practices in Maine?

YES NO

Affidavit of Dentist Applicant

I have read and completed this application and attest that all information is true to the best of my knowledge. Should I furnish any false information in this application, I hereby agree that such act shall constitute cause for denial, suspension or revocation of my license to practice dentistry in the state of Maine.

I hereby authorize all hospitals, institutions or organizations, personal physicians, employers (past and present), business and professional associations (past and present), and all government agencies and instrumentalities (local, state, federal or foreign) to release to the Maine Board of Dental Practice, my references and information, files, or records requested by the Board in connection with processing of this application. I hereby authorize the Maine Board of Dental Practice to use photocopies of this authorization and waiver in lieu of the original.

I further authorize the Maine Board of Dental Practice to release to the organizations, individuals and groups listed above, any information which is material to my application.

Signature of Applicant: _____

Date: _____



STATE OF MAINE
Board of Dental Practice
 143 STATE HOUSE STATION
 AUGUSTA, ME 04333-0143

VERIFICATION OF CLINICAL SUPERVISION FORM

DO NOT SUBMIT THIS FORM UNTIL THE CLINICAL SUPERVISED EXPERIENCE IS COMPLETED

Dentist Applicant Information (To be completed by the Dentist Applicant)		
Name of Licensee:		License Number:
Mailing Address:		
City:	State:	Zip Code:
Work Telephone:		

Dentist Supervisor Information (To be completed by the Dentist Supervisor)		
Name of Dentist Supervisor:		License and Permit Number:
Mailing Address:		
City:	State:	Zip Code:
Work Telephone:		

Clinical Experience Information (To be completed by the Dentist Supervisor)	
Total Number of Adult Clinical Patient Experiences:	
Total Number of Medically Compromised Adult Patient Clinical Experiences:	
Total Number of Pediatric (aged 12 and under) Patient Clinical Experiences:	
Total Number of Clinical Patient Experiences:	
Dates of Supervision: From _____ (month/day/year) To _____ month/day/year	

PLEASE COMPLETE SECOND PAGE

1. Please describe the clinical experiences managed by the dentist while under your supervision.

2. Based upon your assessment, is the dentist prepared to safely perform sedation and/or general anesthesia to patients without supervision?

AFFIDAVIT OF DENTIST SUPERVISOR

I have read and completed this form and attest that the supervised clinical experience information is true to the best of my knowledge. Should I furnish any false information in this form, I hereby agree that such act shall constitute cause for disciplinary action to practice dentistry in the state of Maine.

DENTIST SUPERVISOR SIGNATURE: _____

DATE: _____